Public Listening Session
Tuesday September 15, 2015
6:00pm – 7:30pm
Meeting Minutes

I. **Welcome** –Mayor Scott Avedisian & Secretary Roberts welcomed the crowd to the Buttonwoods Community Center for the first Listening Session of the Working Group for Healthcare Innovation. Spoke a bit about what the Working Group for Healthcare Innovation is, and the charge. Additional background may be found at: http://www.governor.ri.gov/initiatives/healthcare/

II. **Overview of the Working Group for Healthcare Innovation** (Presentation by Secretary Roberts. Overview slides available online and by request via email to lauren.lapolla@ohhs.ri.gov)

III. **Public Comment**: The public was invited to come forward and talk about their experiences with healthcare. The crowd was invited to think about what their experience has been with the healthcare system, where it does a good job, and where there is room for improvement, and also if there is one thing in the system that could be changed, what that might be. If they were willing, there was a request for each speaker to identify her or himself, though not required.

Comments:
Steve Boyle, Cranston Chamber, and Small Employer Health Task Force: here to represent small businesses. It is frustrating to see year after year healthcare Groundhog Day. Rates get higher, businesses struggle, we have to adjust from here. I applaud the effort of the committee to control the cost. I know there has been talk about Massachusetts and cost control, but I feel the state of Maryland has been controlling cost for years and have a lot of data. They also have a novel approach of controlling hospitalization costs. The state does well and changed the global payments. Leave some articles with the staff, we continue the frustrations on the small businesses side as continuing with increases are difficult. It is not just premium control, but it is cost control. Unless we get a hold on those, then in the future we will continue to spiral.

Donna Castricone: I am a registered dietician. I would love to see better reimbursement. I think that is where we fall short in preventative care, at least in nutrition and medical nutrition therapies. These services can really be utilized if the reimbursement is there. I myself have really seen measurable goals, and people that have gotten a lot healthier because they have the services there from a professional.

Secretary Roberts: In RI we have a growing number of primary care providers, with teams. Have dieticians been integrated?

Donna Castricone: Yes, we are in some Primary Care Medical Homes, not in all and not as big a presence. We would love to see that grow, see a dietician in all of those centers, love to see more coordinated care when a patient is discharged from a hospital who may need more care than just a phone call. I think utilizing a licensed registered dietician in a primary care setting keeps them out of hospitals and out of hospitals for readmission.

Anonymous Commenter: My mom had early onset Alzheimer's and she was very unbalanced, went in and out of hospitals. The time frame is really tough going into a nursing home and going right back in, and I think that is where we could see a lot of money going out.

Secretary Roberts: We have a nursing home provider here tonight, and we are in a conversation to help talk about how to help pay for the right supports to stop patient hospital readmission and get them in the right setting. You're right and one of the most challenging issues we have is how we link together LTC and home care services, especially when someone has been in the hospital and the gaps can be significant. We have a great organization, Healthcentric Advisors, focused on improvement and transitions of care. Thank you for reminding us of that, and keeping it in mind.

Secretary Roberts: We all have the wonderful stories, and the not wonderful stories. I will share one about health IT and why it is so important. My husband became quite ill suddenly, used his primary care provider three times in one week. We had to take him to South County Hospital, they checked him out, and sent him home. He did not get better, drove up to the hospital where his primary care provider has care. While admitted, his cell phone rang, and it was a nurse from South County Hospital who called to advise he had Lyme disease. There was no crossover in health IT - the only crossover was the patient. That's the only way they had to inform him. What is wrong in a system that has so many places, that despite paying, despite good care, we don't have those systems checks? Think about a system where we haven't built a structure to support people.

Steve Boyle, Cranston Chamber, and Small Employer Health Task Force: Part of the Maryland thing, why it is so interesting, is in that structure, whatever procedure you receive in the northern part of Maryland is the same in the southern part of Maryland. It is easier for the consumer to work it out. I had a blood clot that became a pulmonary embolism. My primary care provider missed it twice, my chiropractor caught it, and

there was no coordination of care afterwards from the hospital, nor a follow-up call from my then primary care provider.

Keith: I am a single self-employed individual, and my healthcare before Obamacare was $235, my new rate will be $500 and the coverage will be less. We seem to single out single self-employed, not part of a group. I have gone through RI healthcare, say I am over the federal guidelines for subsidies. Same with Blue Cross Direct. The state reflected that in the new budget. Tax businesses at .49, but single or direct pay we tax at 2.75. That was done before the rate increase at Blue Cross. How come you didn't lower the tax on my healthcare, where did the money go? Someone needs to help us out a bit – it was affordable.

Anonymous Commenter: I feel I have a perpetual mortgage with Blue Cross.

Keith: I make $2K more than federal guidelines. Why would you tax the single self-pay triple before the rate increase? Where does the money go? This is where you hear that you say you care about good affordable healthcare.

Anonymous Commenter: I think it is a problem too that there are too many levels of government, have to go through too many levels of health care. My calls are not returned.

Secretary Roberts: You are correct. The 2.69%, love it or hate it, is mostly because they portioned more to those using HealthSourceRI, who can use that way to buy insurance. Mostly individuals who are purchasing, thus put most of that cost onto those buying direct. There are fewer businesses using that approach, thus they taxed it less.

Keith: Then why I am I being sent to BCBSRI? I don't mind a fair share, but the difference is getting astronomical.

Anonymous Commenter: I do purchase my insurance through HSRI, an additional $200 per month more than last year. It took me two months through the system to re-up. I heard that I would be sent an escalation team would call me back, the satellite office kicked me out, and threatened to call the police. I finally took it upon myself to go to the executive office of DHS, I sent the same email to all I could find. Finally in mid-January the state came back. It took 2.5 months. I started the minute they opened in open in enrollment. Jen Deboer at DHS deserves a gold star. No answer from the Governor's office, none from Christine Ferguson's office. I finally did it myself. Why is everything a top military secret? Why not hand out a number for someone at the top who can help me. Now we pay an increase for something that isn't working. The left

hand does not know what the right is doing. I had to write to the Office of the Health Insurance Commissioner to get a check straightened out.

Secretary Roberts: HSRI is a separate government you are correct, but we are doing a lot of quality improvement work with them. It is important to know the federal exchange has a similar cost structure to ours, we modeled as best as possible. It is a complex system. What you speak to goes to the patient experience of care. How we get the access you need, and how to get it in a less complex way. I wish I had a magic wand to fix it. We are thinking about here how to fix how in RI we look for a less complex approach. You speak about rate increases, there are many parts of this country looking at 30, 40, 45% rate increases. For a long time so many where uninsurable, and now all are in. We don't want to leave anyone out of the system.

Keith: Not rewarded for our wellness. BCBSRI was going to reward healthiness, the vanishing deductible, but the state said that couldn't happen.

Sean Donahue, BCBSRI: Given the new ACA federal requirements, we were told that plan didn't comply with those tiers.

Charlie Hewitt, formerly with RIQI: Heard a lot about CurrentCare. One thing to change would be to simply come up with a system to notify primary care providers when a patient utilizes the healthcare system. That would address a situation I had with my mother when she was living being bounced back from hospital to nursing homes.

Secretary Roberts: Right and we have a system for the Emergency Room, but I do not think the nursing homes are tied in, so good point. Thank you.

Anonymous Commenter: I would say better reimbursement for preventative services. Medicare won't pay for you to see a dietician to lose weight, but once you are diagnosed with diabetes the state will pay for visits and insulin, which is far more expensive. Also incentives, some plans out there do incentivize wellness, and I think they are great if people know about them, and follow through with those.

Karen Enright, Retired faculty Nursing RI College: I think a lot of what is being said focuses a lot on what this group can investigate in terms of performance. It cannot be just in general, it needs to be based upon the health needs of the practice, so that if the practice has a high incidence of obesity and diabetes, the incentive should be tied to reducing those targets. If there is a practice with a lot of heart disease, then the incentive should be to provide the services to serve those suffering from those disorders and including preventive work. Within the state of RI there

have been many programs on health, high incidence of certain disorders, and some of the pay for performance where many insurance companies pay back for that, and use those funds to have that care coordination, to have the smoking cessation groups. Needs to be practice specific. You don't want them to do what they have always done for more money, but really look to being innovative.

Frank Ferri, State Representative: I am a small business person, and a state legislator. Having an experience with primary care, I can speak with my primary care provider but will end up in the hospital if the primary care provider is out or inaccessible. I think the lack of coordination is big. That is shifting the cost from one group to another, and that needs to stop. Single payer is good if all are treated the same. It is complicated, there are many moving pieces, we need to be louder, and we need to be part of the solution. On the small employer task force there are good voices there and we can join that. Use many forums to speak to these issues.

Tina Spears, RIPIN: One of the big issues that hasn't been touched upon yet is behavioral health and substance abuse, treating the patient with a whole approach. I raised a child with a serious behavioral health issue and going from specialist to specialist, you get different care. Our organization works a lot with children and families, becoming a crisis for many families with Mental Health and Behavioral Health issues. No capacity to address this need. When thinking about the system that we want, need to be clear to include the mind with the body and ensure that we are delivering parity when talking about benefits, talking about treatment that is coordinated.

Mayor Avedisian: When we created the Wilcox Family Health Center down the street there was a linkage to the Dental, Kent Center to link Behavioral Health center.

Tina Spears, RIPIN: To further expound, benefit structure has to align with that coverage. People need to have access to behavioral health care needs being met.

Anonymous Commenter: The frustration that I have is that the insurance companies are really dictating medical care. If a primary care provider orders a specific medication, and you don't get it covered. I had flesh eating bacteria in my arm, my insurance company didn't want to pay for the surgery, but I had to have it. How to integrate that into this would be good – sever the disconnect between needed care, and insurers deciding what the right care is.

Mike Raia: Full disclosure, I am the Communications Director for EOHHS. Having heard the gentleman earlier talk about Maryland experience I wanted to comment. I lived in Maryland prior to moving back to RI. We had our daughter in Maryland, had a general sense of what the cost would be and the coverage. You didn't know that the on-call doctors would be in plan. Our daughter had some fluid in her nostrils, and if the doctor on call was in our United plan we knew we would just pay the copay, but if not we knew we would get hit with a $1200 cost. We did have that but at least we knew upfront what that would be. That was the Maryland experience for us.

Wanbing Xiong: I am an international student from China. The food in hospitals is not healthy. I volunteer in a hospital Emergency Room. They serve sugary juice boxes, and white bread - how do you expect people to get better and heal faster with food that is not nourishing? The only way to fix them is through medication, which is very costly. You give one person one medication, another patient you may have to also treat for side effects. Why not put money into a healthy food system so that we can build healthy people from the inside out?

Sophie O'Connell, EOHHS: There often seems to be a disconnect that when one goes to a doctor, specialist or dentist, they cannot tell you how much something will cost. You have to call an insurance company. If you have a high deductible, that is unnerving, as it can take a very long time to reach that. In what other life service do you have to pay for the service before knowing the cost? I was once hit with an unknown $1200 blood test, and had no idea it was any different than another blood test. If there is a way to make costs more transparent and accessible, I would strongly advocate for that.

William Hochstrasser Walsh: A few statements. I find it true in the city of Warwick for individuals who are self-employed, too expensive to purchase on the Exchange. In some cases the premium may be cheaper, but the deductible will be extremely high. Prior to the ACA we had a 43% uninsured rate. As an administrator I saw that we dropped down to 20%, but that number is going back up, as folks are seeing that is cheaper to use a health center sliding scale, and a tax penalty, rather than pay towards that high deductible. This in between group is badly hit. One of the things hardly spoken about is tort reform; one thing that drives the cost of healthcare up in this country are millions of dollars of lawsuits against providers. If there was a system where a provider felt okay not reordering a test from two weeks ago, just to cover their bases. We do have a high rate of re-ordering tests, but we need to be sure that we have on the record we have ordered tests and we have done due diligence. That really speaks to tort reform. If we can contain the malpractice lawsuits, not sure what needs to be done, but I know that drives

premiums.

James Raiola: I am a part of the working group, have been working in this industry for 30 years, and I see good and not so good. The comments you make are very useful. Five, ten years ago all these seats were filled. Good news is that if one is eligible for subsidies, one is now paying little to very little and getting coverage. Larger employers are not providing meaningful coverage. Many Americans now getting affordable coverage; where the law misses out, where we hear the dissent is those just over the subsidized level, in a pool that gets the last look. Not the most lucrative pool, where there are high claims. The way to solve that problem is maybe two fold: carriers come up with ingenious plans, tiered networks, to get people access to a decent number of docs at a decent cost. The second is that in this state, we are in a state of recovery. If RI can continue to take a hatchet to the unemployment number, then those folks will have more access to employer coverage. We have a few pockets left we need to take care of, and half of that problem is to get us where we are not ranked in the bottom third of economic climate.

Anonymous Commenter: All you say is true, but one problem is that small groups pay a lot more than largest groups. Individuals pay more as well. In RI, the majority of people who work for those companies with smaller group. As the definition of small group changes from 50-100 next year, you may pay more for insurance. How will we adapt to that, how are we prepared for that? Could that increase not prevent small employers from hiring people? Once that definition changes, roughly 51% will work for a small business.

Josh Miller, RI State Senator: One thing that gets left behind often are direct payers. We have been trying to do a lot but have done very little about that, about how large plans are designed. Large plans often keep costs down through a larger co-pay, adding expense to their employees. The woman in the back who spoke about transparency and what to pay: we just passed a law a few months ago saying that if you had expenses over $5,000 the hospitals had to tell you within five days what you have to pay. Certain hospital groups wanted to fight over how many days. They argued over five business days or consecutive days; I said that when they stopped admitted people on weekends I would support five business days. We did get it to $5,000, and five days. They weren't ready to have those conversations, but we needed to, and moved forward. It's why a group like this is so important as it gives a voice to groups that we do not usually hear from.

Brenda Whittle, NHP: I have a personal experience to share. My mother is in the end of her life, and what I would change is how we handle end of life care. It is natural, and it happens. My mother wants a very dignified

end, at home with her family. My family has been so fortunate to be in the medical fields, so we wrapped our family around the end of her life. I realize that so many people do not have those options. One of the best things we can do is the recognition of that point. Provide the dignified services the patient wants. Things happen, we have to be able to put things in place in this country so that the natural end of life happens in an affordable way.

Mayor Avedisian: How many people in the room have the primary care provider cell phone? (About six out of thirty raised their hands). I think that is a big part of where the system has changed, no longer that personal conversation. How many have a primary care provider? (Almost the whole room raised hands).

Josh Miller: We wanted years ago to include a requirement to have a patient list primary care provider on their insurance form, to expand primary care, and we had a lot of push back from an insurer.

Mayor Avedisian: It was interesting for me to see employee records with redacted names, and how many write Kent Hospital Emergency Room as their primary care provider.

Anonymous Commenter: Concern about doctor shortages, how do we keep and attract docs, so you don't have to go to the ER.

Donna Castricone: Good point - at the hospital I used to work at many residents headed out of state due to jobs, or pay.

IV. **Adjourn:** Mayor Avedisian and Secretary Roberts thanked everyone for their thoughtful comments, stories and questions. Both expressed appreciation and advised these comments would be available for the Working Group to read and consider as they make their recommendations.